State Plan for Mental Health Services Fiscal Year 2005

Family and Social Services Administration

Division of Mental Health and Addiction

September 1, 2004

#### **FACE SHEET**

# FISCAL YEAR/S COVERED BY THE PLAN (Please check as appropriate) FY 2002-2004 FY 2003-2004 X FY2005

STATE NAME: Indiana DUNS # 196256994 AGENCY TO RECEIVE GRANT AGENCY: \_\_\_\_ Family and Social Services Administration ORGANIZATIONAL UNIT: Division of Mental Health and Addiction STREET ADDRESS: 402 W. Washington Street, Room W353 CITY: <u>Indianapolis</u> STATE: <u>Indiana</u> ZIP: <u>46204</u> TELEPHONE: <u>317-232-7866</u> FAX: <u>317-233-3472</u> II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR **ADMINISTRATION OF THE GRANT** \_\_\_\_TITLE: Director NAME: Suzanne Clifford AGENCY: Family and Social Services Administration ORGANIZATIONAL UNIT: <u>Division of Mental Health and Addiction</u> STREET ADDRESS: 402 W. Washington Street, Room W353 CITY: <u>Indianapolis</u> STATE: <u>Indiana</u> ZIP: <u>46204</u> TELEPHONE: 317-232-7866 F AX: 317-233-3472 III. STATE FISCAL YEAR FROM: July 1, 2004 TO: June 30, 2005 IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION NAME: <u>Sue Lummus</u> TITLE: <u>Deputy of the Office of Policy and Planning</u> AGENCY: Family and Social Services Administration ORGANIZATIONAL UNIT: Division of Mental Health and Addiction STREET ADDRESS: 402 W. Washington Street, Room W353 CITY: Indianapolis STATE: Indiana ZIP: 46204 TELEPHONE: 317-232-7824 FAX: 317-233-3472 EMAIL: slummus@fssa.state.in.us

### **Table of Contents**

Face Sheet			1
Executive Sur	mmary		4
Part B Admi	nistrative	Requirements	6
I.	Federal F	funding agreements, Certifications and Assurances	
	(1) Fundi	ng agreements	7
	(2) Certif	fications	11
	(3) Assur	rances	14
	(4) Gover	rnor's Designation Letter	17
	(5) Public	c Comments on the state plan	18
II.	Set Aside	for Children's Mental Health Services Report	19
III.	MOE		19
IV.	State Mer	ntal Health Planning Council Requirements	20
		1. Membership requirements and Purpose	21
		2. Membership List and Composition	22
		3. MHPC comments and recommendations	27
Part C. State	Plan		29
<b>Section I.</b> De	scription of	f State Service System	30
		n and Analysis of the Service Systems Strengths, Needs, and	
Priorities – A			37
		n and Analysis of the Service Systems Strengths, Needs, and	
Priorities - Ch			51
		e Goals and Action Plans to Improve the Service System	
Adult			64
	,	nt Activities	
	i.	Comprehensive community-based mental health services	64
	ii.	Mental health system data epidemiology	66
	iii.	Not applicable	
	iv.	Targeted services to rural and homeless populations	67
	v.	Management systems	67
	vi.	Goals, Targets and Action Plans	
Childı	en's Plan		69
	· ·	nt Activities	
	i.	Comprehensive community-based mental health services	69
	ii.	Mental health system data epidemiology	71
	iii.	Children's services	72
	iv.	Targeted services to rural and homeless populations	73
	v.	Management systems	74
	2.) Goals,	, Targets and Action Plans	

## **EXECUTIVE SUMMARY**

#### **Executive Summary**

The Indiana Family and Social Services Administration, Division of Mental Health and Addiction (DMHA) adopted the Hoosier Assurance Plan (HAP) in 1994. The Hoosier Assurance Plan continues to be the guiding plan on how we relate to and fund the mental health service system. It represents an improved way to manage public funds earmarked for mental health services, assuring that priority will be given to individuals in greatest need. Under this plan, the Division of Mental Health and Addiction (DMHA) acts as a purchasing agent, contracting with qualified mental health and addiction providers offering an array of individualized mental health and addictions care.

The mission of the DMHA is to assure the availability of accessible, acceptable, and effective mental health and chemical addiction services for Hoosiers. Toward this purpose the Division has statutory authority for six (6) state-operated facilities, and contracts with thirty-one (31) private not-for-profit community mental health centers.

The Indiana mental health system provides services in all ninety-two counties of the state. With the elimination of traditional service areas, consumers have the choice of two or more services providers in most areas of the state. This coverage is demonstrated in the tracking of service provided in rural areas of the state that shows an individual living in rural Indiana has the same probability of being served as does someone in urban areas of the state.

All providers must provide a Continuum of Care as defined in Indiana Code and by rule. This assures that all individuals served have access to a full array of services ranging from inpatient treatment to medication monitoring.

The mental health centers are operating as the gatekeeper for state hospital admissions creating a system in which the community provider continues as an active partner during a state hospitalization and is actively involved in discharge planning. Each mental health center, through bed allocation, has a limited number of state hospital beds for their use.

The Division has a ten year history of moving funds from the state operated facility budget to community based services. The Division remains committed to continuation of this dedication to community based services.

#### Achievements

- Approval of 1915 (c) Home and Community-based Medicaid pilot waiver to serve children who are eligible for state hospital admission with community-based care if that care is less than the cost for one year of hospitalization.
- State funded Systems of Care is now available in 50 % of the state. The Systems of Care technical assistance center, in its second year, expanded its coaching, mentoring and training services to assist new, developing and existing systems in their growth.
- Indiana was selected to participate in the Child Welfare Policy Academy to develop the Early Identification and Intervention Initiative.

- The DMHA Office of Consumer and Family Affairs offers advocacy training for any/all family groups or individuals. The Indiana Federation of Families provides onsite consultation to any group of parents/caregivers expressing an interest in forming a support network.
- DMHA has adopted the Presidents New Freedom Commission recommendations as a vision.
- DMHA has established three major priority areas: Children; Employment and Recovery Outcomes.
- DMHA has finalized the amendment to the Medicaid rule establishing the Assertive Community Treatment (ACT) daily rate.
- Continued implementation of Evidence Based Practices including Assertive Community Treatment, Integrated Dual Diagnosis Treatment, Illness Management and Recovery and Supported Employment.
- DMHA has taken steps to redesign the reassessment of persons in treatment to provide more meaningful outcome based data.

The Indiana Division of Mental Health and Addiction is proud of the present mental health system and is dedicated to continued improvement of that system. Indiana has a history of promoting community based care and we will continue that effort.

## Part B

Administrative Requirements, Fiscal Planning Assumptions, and Special Guidance

Signed copy on file at DMHA

Standard Form Certifications

Signed copy on file at DMHA

Standard Form Certifications

Signed copy on file at DMHA

Standard Form Certifications

Signed copy on file at DMHA

Standard Form Assurances – Non-Construction Programs

Signed copy on file at DMHA

Standard Form Assurances – Non-Construction Programs

Signed copy on file at DMHA

Standard Form Disclosure of Lobbying Activities

Signed copy on file at DMHA

Letter from Governor Joseph E. Kernan designating signatory authority for Mental Health Block Grant application to director of the Division of Mental Health and Addiction on file at DMHA.

#### **Public Review of the Block Grant**

This is a new requirement this year and we are planning several mechanisms to respond.

The Block Grant application has been reviewed by the Mental Health Advisory Council, a public body separate from the planning committee. There is also a separate advisory committee for the office of consumer and family affairs that will have a copy to review. The Indiana Council of Community Mental Health Centers will be given copies for review. The plan will also be distributed to Indiana NAMI for review by the membership of the NAMI affiliates in the state.

The Division of Mental Health and Addiction maintains a website and the plan will be posted to that site. Announcements in the major Indiana newspapers will be made to draw the attention of the general citizenry to the availability of the plan on the website.

### **FFY 2005**

### MENTAL HEALTH SERVICES BLOCK GRANT

### MAINTENANCE OF EFFORT

Data reported by State Fiscal Year July 1, 2003 to June 30, 2004

State Expenditures for Mental Health Services

2004	2003	2002
\$114,600,999	\$111,822,862	\$108,499,955

### SET ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES

Data reported by State Fiscal Year July 1, 2003 to June 30, 2004

	Base Year 1994	2003	2004
Block Grant State Funds for Children	\$ 2,875,417	\$ 2,990,918 \$14,833,078	\$ 3,015,500 \$16,485,578

## **Mental Health Planning Council**

### **Article I -Name**

The name of this unincorporated association shall be the Indiana State Mental Health Planning Council (the "Council").

### **Article II -Purpose**

The purposes of the Council shall be: (1) to exchange information and develop, evaluate and communicate ideas about mental health planning, (2) to write and/or amend the Federal Mental Health Services Block Grant plan for mental health services in the State of Indiana and recommend the plan to the Indiana Division of Mental Health and Addiction, (3) to advise the Indiana State Government concerning proposed and adopted plans affecting mental health services provided or coordinated by the state and the implementation thereof, (4) to monitor, review and evaluate the allocation and adequacy of mental health services in Indiana and to advise the Indiana state government concerning the need for and quality of services and programs for persons with mental illness in the state, and (5) to develop and take advocacy positions concerning legislation and regulations affecting mental health.

### **Article III – Membership**

#### Section 1. Qualification

Council membership composition shall follow the guidelines set forth in P.L.102-321 and any subsequent federal regulations pertaining to council membership. The Council shall determine Status as a "provider" of mental health services upon recommendation of the Nominating/Membership Committee. Such determination shall be made upon recommendation of appointment by the Council and may be changed upon receipt of new or changed information. In order to facilitate such determination, applicants for and members of the Council shall be required to disclose to the Nominating/Membership Committee any work regularly performed for pay as or for a provider of mental health services.

- (a) Organizations or individuals that spend 50% or more of their budget or paid time providing mental health services shall be considered as providers.
- (b) Volunteers and advisory and governing board members shall not be considered as providers solely because of such status.
- (c) Under general ethical principles, members of the Council shall excuse themselves when they have a direct financial stake in the outcome of a Council decision, independent of their status as a provider.

### Section 2. Appointment

Membership shall be by appointment of the Director of the Indiana Division of Mental Health and Addiction or their designee. From time to time, the Council may recommend appointment of new members or removal of existing members. Failure of the Director or designee to veto such recommendation within thirty days of mailing shall constitute approval of the recommendation.

## **List of Planning Council Members (Table 1)**

Name	Type of Affiliation	Agency or Organization	Address, Phone & Fax
Ronda Ames	Consumer	Key Consumer Org	2506 Willowbrook Pkwy, #199 Indianapolis, IN 46205 (317) 205-2500
Trace Benedict	Provider	Tri-County Opportunity School	599 S. Harbor Drive Noblesville, IN 46060 (317) 773-5321 ext.101
Jane Bisbee	State Employee	Indiana Child Protection Svcs.	402 W. Washington St., W392 Indianapolis, IN 46204 (317) 232-4423
Susanne Blix, MD	Provider	IU School of Medicine	702 Barnhill Dr Indianapolis, IN 46202 (317) 274-4065
Lisa Carrico	State Employee	LaRue Carter Hospital	2601 Cold Spring Road Indianapolis, IN 46222 (317) 941-4160
Margaret Carrico	Advocate	Eli Lilly & Company	2458 E. 500 N. Greenfield, IN 46140 (317) 276-9199
Wendell Chinn	Provider	Veteran's Administration	4424 Devon Drive Indianapolis, IN 46226 (317) 554-0000 ext. 4191
Dorothy Conklin	Parent of Child	Marion County Auditor	4811 Charney Ave Indianapolis, IN 46226 (317) 327-8638
Richard DeHaven	Provider	Center for Mental Health	P.O. Box 1258 Anderson, IN 46015 (765) 641-8161
Nancy Edgerton, PhD	Provider	Hamilton Center, Inc.	620 8 <sup>th</sup> Ave Terre Haute, IN 47804 (812) 231-8377
Roger D. Fisher, Jr.	Provider	Indianapolis Psychiatric Associates	8820 S. Meridian St., #255 Indianapolis, IN 46217 (317) 865-6922
Mike Flores	Advocate	IN Developmental Training Center	11075 N. Pennsylvania St Indianapolis, IN 46280 (317) 815-0505

	Type of Affiliation	Agency or Organization	Address, Phone & Fax
Name			
Penny Fouts	Advocate	Miami Nation of Indians of Indiana	80 W 6 <sup>th</sup> St Peru, IN 46790-0041 (765) 473-9631
Ardith Gardner	Parent of Adult	Indiana NAMI	5047 Graceland Indianapolis, IN 46208 (317) 925-9399
Brenda Hamilton	Parent of Child	Indiana Federation of Families for Children's Mental Health (IFFCMH)	2205 Costello Drive Anderson, IN 46011 (765) 643-4357
Myrna Hobbs	Advocate		5219 N. Keystone Avenue Indianapolis, IN 46208 (317) 253-1961
Jim Hurst	State Providers Representative	IN Council of Community MH Centers	101 W Ohio St, #610 Indianapolis, IN 46204 (317) 684-3684
Larry Jimison	Provider	Indianapolis Urban League	777 Indiana Avenue Indianapolis, IN 46202 (317) 693-7603
Elizabeth Krajeck	Parent of Adult		4911 N. Kenwood Avenue Indianapolis, IN 46208 (317) 253-5452
Winston Larry	Provider		1100 West 6 <sup>th</sup> Ave Gary, IN 46402 (219) 885-4264
Stacey Lawrence- Campbell	State Employee	Indiana Housing Finance Authority	115 W Washington St Indianapolis, IN 46204 (317) 232-7754
Virgil Macke	Provider	Hamilton Center	2849 E Northwood Ave Terre Haute, IN 47805 (812) 231-8345
Charles Matsumoto	Advocate		849 Reda Road Indianapolis, IN 46227 (317)888-8505
Edwin (John) McIlvried, PhD	Advocate	University of Indianapolis	3201 Tulip Dr Indianapolis, IN 46227 (317) 788-3274
Pamela Morrison	State Employee	Indianapolis Housing Authority	1919 N Meridian St Indianapolis, IN 46202 (317) 261-7268

Name	Type of Affiliation	Agency or Organization	Address, Phone & Fax
Kathleen O'Connell, Ph.D.	Advocate	Associate Dean, School of Health Sciences	2101 E. Coliseum Blvd., IPFW – NF142 Fort Wayne, IN 46805 (260) 481-5795
Robert Ohlemiller	State Employee	Department of Corrections	302 W Washington St, E334 Indianapolis, IN 46204 (317) 232-5706
Keith Oldknow	Consumer	Mental Health Association in Indiana	1431 N. Delaware Street Indianapolis, IN 46202 (317) 638-3501
Deka Oliver	State Employee	Deaf & Hard of Hearing Services DDARS	402 W Washington St, W453 Indianapolis, IN 46204 (317) 232-1143
Craig Peterson	Parent of Child	Indiana Parents Information Network	4107 Langwood Ct. Indianapolis, IN 46268 (317) 872-2870
Deborah Pope	Consumer		900 Noble Run #D Noblesville, IN 46060-5224 (317) 770-0645
Anita Price	Advocate	AARP	124 Dominion Drive Zionsville, IN 46077 (317) 873-3400
Cheryl Prochaska	Parent of Child	Reach for Youth	2802 Punto Alto Circle Indianapolis, IN 46227 (317) 888-4154
Dennis Rhyne, MD	State Employee	Office of Medicaid Policy & Planning	402 West Washington St W382 Indianapolis, IN 46204 (317) 233-5725
David Rollock, PhD	Advocate	Purdue University	Dept of Psychological Sciences W. Lafayette, IN 47907 (765) 494-6996
Nathan Rush	Advocate	Bethlehem House	8577 One West Drive #104 Indianapolis, IN 46260 (317) 466-7722
Sven Schumacher, MSW	Provider	Lutherwood Child & Family Services	1525 North Ritter Ave Indianapolis, IN 46219 (317) 353-8211

Name	Type of Affiliation	Agency or Organization	Address, Phone & Fax
Elizabeth Skafish	Provider	Midtown Comm. Mental Health Center	1001 W. 10 <sup>th</sup> St, Room BU441 Indianapolis, IN 46202 (317) 630-8485
Judy Spray	Advocate	Marion County Public Defender Agency	129 E Market, #700 Indianapolis, IN 46204 (317) 327-6869
Demaris Stewart	State Employee	Department of Education	State House Room 229 Indianapolis, IN 46204 (317) 232-0592
Roz Summerlin	Provider	Center for the Homeless, Inc.	813 S. Michigan Street South Bend, IN 46601 (574) 282-8700
Sharese A. Swafford, LMHC	Provider	Outreach & Service Development	P.O. Box 809 Goshen, IN 46527 (574) 537-2630
Karen Swarts	State Employee	Vocational Rehab Services	402 W. Washington St, W453 Indianapolis, IN 46204 (317) 232-1307
David Thomas	Consumer	Key Consumer Org	2506 Willowbrook Pkwy, #199 Indianapolis, IN 46205 (317) 205-2500
Harold Thompson	Advocate	SENIORS UNLIMITED	11711 N Meridian St #580 Carmel, IN 46032 (317) 843-5280
Adriana Torres	Advocate		3240 N. Franklin Road Indianapolis, IN 46226 (317) 850-2702
Marge Towell	Provider	Mental Health Assn of Marion County	2506 Willowbrook Parkway Indianapolis, IN 46205 (317) 251-0005
Gabe Valenzuela	Provider	BehaviorCorp, Inc.	697 Pro-Med Lane Carmel, IN 46032 (317) 574-0055
Deborah Washburn	Parent of Child	NAMI-Indianapolis	3665 Power Dr Carmel, IN 46032 (317) 844-4047
Gilbert Winkel  Planning Council Compos	Parent of Adult	Retired	4505 Mayfield Dr Kokomo, IN 46901 (765) 452-1207

Planning Council Composition by Type of Member (Table 1A)

Type of Council Members	Total Members
Consumers	4
Family Members of Children with SED*	5
Family Members of Adults with SMI	3
Vacancies	0
Individuals other than state employees and providers of mental health services	25
Individuals who are state employees and providers of mental health services	25

# Mental Health Association in Marion County

2506 Willowbrook Parkway, Suite100 • Indianapolis, IN 46205-1542 • Phone: (317) 251-0005 • Fax: (317) 254-2800 www.mcmha.org

August 23, 2004

Marjorie A. Towell Executive Director

BOARD OF DIRECTORS Executive Committee

Dan G. Collins President

Mike Simmons Vice President President-Elect

Diane B. Willis Secretary

David S. Vonnegut-Gabovitch Treasurer

Shary Johnston Immediate Past President

Steven L. Meyer Cindy Simon-Skjodt

Tanner Marles Young

**BOARD MEMBERS** 

DeLois Dilworth-Berry Angela Cain Marcia Capuano Janet Corson Andrew Dietrick Joel L. Gauthier, CPA Robert W. Hammerle Deng Rae Hancock Frederick Hash Donna Hopf Jeri Huntington Sheila Suess Kennedy Paul Lefkovitz, Ph.D. Leah Mannw The Rev. Rachel Metheny Matthew B. Murphy, III Doris Peck David Reed Jackie Bawie Suess Pamela Wright, M.S., LMFT, LMHC Linda C. Zappia

Honorary Directors Harriet P. Irsay Marjorie C. Tarplee

A CHAPTER OF: Mental Health Association in Indiana

National Mental Health







LouEllen M. Rice Grants Management Officer Division of Grants Management OPS, SAMHSA 5600 Fishers Lane Room 13-103 Rockville, MD 20857

Dear Ms. Rice:

The Indiana Mental Health Planning Council reviewed the Block Grant application and provided input to the plan. Planning Council members had several opportunities to provide input to the draft application during their sub-committee meetings. Upon completion of the draft it was then forwarded to the Planning Council members for further review and comments prior to our council meeting August 20<sup>th</sup>. At the August meeting the sub-committees reviewed the updated draft and made further recommendations to be incorporated into the plan or to be included in this letter for further discussion and/or consideration. After close scrutiny, the Planning Council unanimously approved the plan at the August 20<sup>th</sup> meeting.

Many of the recommendations of the Planning Council will be incorporated into the plan, however; the council wanted to include the following concerns and/or gaps in the service delivery system that should be considered priority as we move forward:

- We do not have adequate resources to address transitional services transition from school to community—transition from jail to community transition from child to adult. The growth in Systems of Care has expanded the capacity to deal with a limited number of transition challenges, but the need far exceeds the capacity of the SOC.
- 2. As the state budget is reduced the county match for the Medicaid dollars is likely to be depleted in the near future. Non-Medicaid eligible children are not being served in most systems. Despite Indiana's commitment to expanding and nurturing Systems of Care, we are approaching a capacity issue because of the reliance on Medicaid funding for the majority of children served.

changing attitudes improving lives

- 3. We do not accurately reflect the number of children/youth served with substance abuse issues as the current reporting system limits options for enrolling youth.
- 4. Individuals with a dual diagnosis, MI/DD, are underserved or in many cases not served. There is little, or no, system coordination between the MR/DD system and the MI/SA system or data banks.
- 5. Individuals with mental illness often face long waiting list for admission to mental health center treatment.
- 6. Peer Support Services and consumer involvement at the mental health centers should be explored further.
- 7. Individuals seeking employment opportunities face long details before authorization is approved for supported employment through Vocational Rehabilitation. Greater coordination between the DMHA and Vocational Rehabilitation systems and additional resources are needed for employment activities.
- 8. Exploring the possibility of accreditation of case managers could possibly reduce the turnover rate of case managers.

The planning council is appreciative of the DMHA staff and their efforts to involve the council in the planning process. Further, we are encouraged by the opportunity to have greater input into the planning process and look forward to working in partnership with the DMHA to explore possible solutions to the concerns identified above.

Sincerely,

Marjorie A. Towell, Chair

Mental Health Planning Council

Jargine a. Swell

Page 2, Indiana DMHA

Indiana 28

## Part C. State Plan

## Section I – Description of State Service System

### Section I.

### **Description of State Service System**

The Division of Mental Health and Addiction has adopted the following vision:

We envision a future when everyone with mental illness or an addiction will recover, a future when mental illness can be prevented or cured, a future when mental illness and addiction are detected early, and a future when everyone with a mental illness or addiction at any stage of life has access to effective treatment and supports-essential for living, working, learning and participating fully in the community. (The President's New Freedom Commission on Mental Health, Final Report, July, 2003)

#### Organization of the SMHA

The Division of Mental Health and Addiction is a part of a larger agency called Family and Social Services Administration (FSSA). The Indiana Family and Social Services Administration is the overarching, administrative organization for several human service entities. The agency has four main divisions: Division of Family Resources; Division of Mental Health and Addiction; Division of Disability, Aging and Rehabilitative Services; and Office of Medicaid Policy and Planning. The divisions report to the FSSA Secretary, who is a member of the Governor's cabinet. Created in 1991 by the Indiana General Assembly to better integrate the delivery of human services, it employs 9,700 persons, and has offices in all 92 counties.

The Division, as part of FSSA, has constant contact with several major "sister" service agencies and our ongoing working relationships with Health, Corrections, and Education complete a wide range of cooperation with other state agencies.

The Division of Mental Health and Addiction is actively involved with the Department of Correction (DOC) in several areas including monthly summit meetings and ongoing meetings on children's issues. This office has been working with DOC on the development of community corrections programs that will include mental health treatment.

DMHA has participated as a "core partner" with the Indiana State Department of Health in planning for a more comprehensive early childhood system. In this process state agencies, community partners and families collaborate to develop a strategic plan leading to a coordinated, comprehensive, community-based system of service for young children. This process is supported by a planning grant from the Federal Maternal and Child Health Bureau.

DMHA is represented on the Governor's Interagency Coordinating Council on Infants and Toddlers, First Steps state panel and Head Start state panel. We convene a quarterly gathering of various child serving state and private agencies for the purpose of cross-systems collaboration toward shared goals.

The Division is represented on the Interagency Council on Homelessness and has been actively involved in the preparation of the Indiana plan to end chronic homelessness.

Description of the State Mental Health System

The Division of Mental Health contracts with privately owned not-for-profit mental health centers for the provision of care. The guiding plan for mental health services is found in the Hoosier Assurance Plan (HAP) as developed following mental health reform legislation in 1994. That reform and the resultant HAP substantially changed the relationship DMHA has with the provider system. Funding changed from a deficit funding system to a payment system based on enrollment of and services for a targeted population: those at or below 200% of poverty. This focuses our funding on the poor and enables DMHA to assure that treatment funds are used for the neediest population.

The contracted providers have 117 service sites throughout the state. All ninety-two counties at least one provider with an office located in the county. We are very proud to say that the penetration rates in rural Indiana are equal to the rates in urban Indiana.

The HAP eliminated the traditional catchment areas and encouraged the development of multiple service providers in any area. This has produced real consumer choice as in most areas of the state there is more than one provider from which to choose. In some of the more populated areas of the state there are four or more providers from which to choose.

Indiana providers are required by law and by contract to provide a Continuum of Care that delineates the full array of services that are to be available to anyone enrolled in treatment services. The Continuum of Care has been further defined in certification rules. The Continuum of Care will be discussed in more detail in both the adult and children's Section II. Case management, a required part of the continuum of care is also defined in Indiana Code and further regulated by rule. This will also be further discussed in section II.

The DMHA instituted a gatekeeper practice wherein the mental health centers are responsible for entry into and exit from a State Hospital. The referring mental health center is required to participate in the treatment planning and discharge planning for everyone admitted to a State Hospital. This has created a system in which people referred to a state facility are no longer placed and forgotten. This has also strengthened the ties between the state hospital and the mental health centers.

This office has assigned to each provider a number of State Hospital beds that they can use. The allocation is based on the population in need of services in an area. This has created a system where each provider has a limited number of beds to use and eliminates the overuse by any one provider. We presently have 828 state hospital beds allocated to the community mental health centers. The number of beds is not static since the availability of beds is influenced by the number of admissions that are not under the control of the mental health centers such as outdates from corrections and forensic admissions.

The development of Children's Systems of Care has been seeded by state funding since 2000, and now encompasses approximately 50% of the state. Indiana also has 2 federally funded Systems of Care sites; the Dawn project in Marion County and Circle Around Families in Lake County.

The Crisis Counseling Program supports mental health interventions including outreach and education, as well as short term interventions with individuals and groups experiencing psychological trauma due to large scale disasters. During 2003, over 6,200 persons affected by widespread flooding were served. A statewide conference is planned to cover disaster mental health and crisis counseling in late 2004. This office is also very active in assisting in the local and state plans for responding to terrorists.

DMHA has long been concerned about the provision of treatment that is culturally competent. All providers have made use of training that we have offered via contract with a training agency.

Ten years ago we closed a state hospital and moved virtually that entire budget to the community based treatment budget. We have continued to downsize state hospitals and move budget savings to the community.

The Community Systems Data System (CSDS) was instituted in 2001. This is a statewide database system that collects detailed demographics and diagnostic information regarding persons enrolled in services from all treatment providers. It also tracks treatment encounters over the course of treatment for each individual served by the funded providers in Indiana. It has greatly increased our understanding of the services provided and has made it possible to comply with the data collection requirements of the Mental Health Block Grant.

### Summary from prior plans -- needing attention

During the review of last year's plan the reviewers asked us to consider three things: the council by-laws pertaining to the director's power of veto on a recommendation to remove a member; the definition of advocate; and the consumer-family voice in the planning council.

The veto power issue was discussed by the state planning council, and the council agreed that the veto power of the director presented no problem and no action needed to be taken.

**Definition of advocate**: At the most recent meeting of the planning council, a definition of advocate was adopted. An advocate is a knowledgeable person who is actively involved in articulating the need of consumers and their families and who demonstrates a personal commitment to furthering the quality of life for persons with an emotional disorder or a mental illness.

Consumer/family voice: A survey of the planning council was made with mixed results. The family members feel there needs to be a larger representation of this group in the Planning Council to assure representatives the confidence to speak up. Expanding consumer/family participation will also bring additional concerns to the table. If there is expanded consumer/family representation absences or emergencies will not necessarily compromise an honest and candid participation. The majority of the consumers felt that they did have a voice but would like to have more consumers on the planning committee. This issue will be further addressed by the council during this fiscal year.

### Summary from prior plans -- significant achievements

We continue to see increases in our implementation of Evidence Based Practices especially Assertive Community Treatment (ACT), Illness Management and Recovery (IMR) and Integrated Dual Diagnosis Treatment (IDDT). We will be adding five new pilot projects to ACT during state fiscal year 2005. We will be implementing IMR at six pilot sites over a two year period under a SAMHSA grant. There are seven pilots involved in IDDT.

The Indiana Medicaid rule was changed in state fiscal year 2004 to include a daily rate for ACT. The Division expects continued growth in the availability of ACT as more programs begin or the number of ACT teams expands. Supported employment has been in existence for almost ten years in Indiana, and we expect additional supported employment programs to start during the coming year.

In February we were awarded a 1915 (c) Home and Community-based Medicaid Waiver for children. The waiver provides a community-based option for children who are eligible for state hospital admission.

#### Legislative issues

There were three bills passed in the Indiana general assembly in the 2004 session that affected the DMHA. The law relating to an insanity defense was changed to allow for competency restoration to occur in any setting. A bill concerning psychiatric advance directives was passed that allows certain individuals to execute a psychiatric advance directive and sets forth requirements for a psychiatric advance directive. The third new law requires training in interacting with persons with mental illness, addictive disorders, mental retardation, and developmental disabilities for law enforcement personnel, jail officers, probation officers, and correctional officers.

### SMHA leadership in coordinating MH services

At the request of the Lt. Governor, DMHA has taken the leadership role in bringing together initiatives that will positively affect Hoosier children through Indiana's Peak Performance Plan. In collaboration with the Indiana State Department of Health, Division of Family Services, the team has defined measurable outcomes that will assure that children grow and thrive. Specifically, immunization rates will be increased, results for children and families receiving services from multiple systems will improve with the introduction of systems of care teams and the implementation of routine mental health screening, assessment and treatment for children who need to be removed from their home will improve placement results.

DMHA has lead a cross-system initiative to launch an Early Identification and Intervention plan to administer mental health and addiction screening to all children entering the child welfare system. The system's partners are: Family and Social Services Administration, Division of Family Resources, Department of Correction, Department of Special Learners, Juvenile Justice Improvement Committee, State Budget Agency and the Indiana Federation of Families.

The Director of the DMHA has established three major priority areas for the Division: Children; Employment and Recovery Outcomes. These areas have been incorporated in the Divisions goal statements for FSSA.

# Section II. Identification and Analysis of the Service Systems Strengths, Needs, and Priorities

# Section II. – Adult Mental Health System Identification and Analysis of the Service Systems Strengths, Needs, and Priorities

# Criterion 1

# **Comprehensive Community Based Mental Health System**

Organizational structure of the system

The Indiana mental health service system provides access to treatment services throughout the state. This office contracts with thirty-one private not for profit community mental health centers that provide a full continuum of care in all areas of the State. There are 117 service sites throughout the state.

Through the implementation of the Mental Health Reform Legislation in the early 1990s, we substantially changed the way we do business with the mental health centers. The Hoosier Assurance Plan resulted from that legislation. The Hoosier Assurance Plan eliminated the traditional service areas for providers. The desire was to increase consumer choice of providers and there is now a choice of at least two providers in more than half of the counties in the state.

There is a defined relationship between the state operated hospital system and the state supported community mental health center system. The thirty-one community mental health centers serve as the gatekeepers for State Psychiatric Hospital admissions and discharges. The admitting mental health center is required, by rule, to be involved in the treatment of an individual during hospitalization and to participate in the discharge planning. We formalized the gatekeeper role by promulgating a rule that spells out in administrative code the responsibilities of the gatekeeper. The mental health centers and the State Hospitals are now acting more in concert in the return of individuals to the community. There is also a bed allocation process through which each provider has a number of state hospital beds to use. That allocation is based on the population served by the provider.

#### Available Services and Resources

The services required of mental health centers are listed in Indiana Code 12-7-40.6 "Continuum of Care". Continuum of care means a range of services the provision of which is assured by a community mental health center or a managed care provider. The term includes the following:

- 1. Individualized treatment planning to increase patient coping skills and symptom management, which may include any combination of the services listed under this section.
- 2. Twenty-four (24) hour a day crisis intervention.
- 3. Case management to fulfill individual patient needs, including assertive case management when indicated.
- 4. Outpatient services, including intensive outpatient services, substance abuse services, and treatment.
- 5. Acute stabilization services including detoxification services.
- 6. Residential services.
- 7. Day treatment.
- 8. Family support.

- 9. Medication evaluation and monitoring.
- 10. Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty.

Each community mental health center guarantees, under contract with this office, the provision of the above services.

In addition to the required Continuum of Care, Community Support Services was added as a mandated service in 1988. This required a number of activities that include coordinated case management services, outreach, assessment and diagnosis, crisis intervention, psychiatric treatment including medication intervention supervision, counseling and psychotherapy, activities in daily living, psychosocial rehabilitation services, client advocacy, residential services, recreational activities, vocational services, and educational services. Community Support Services are also responsible for the admission and discharge planning of persons entering and returning from the state hospitals.

The movement to increase the level of community services was accelerated by the closure of a state-operated psychiatric hospital, the downsizing of other state psychiatric hospitals and the movement of the state budget savings to the community. As a result of this movement of funds, there has been an expansion of community based services throughout the state. We are continuing with a community development strategy that promotes the movement of state funds from the hospital system to the community system in order to reduce the use of the state psychiatric hospital system.

#### Evidence Based Practices

In 2000, DMHA standardized Assertive Community Treatment (ACT) in the state. To assist us in developing ACT, we funded the ACT Technical Assistance Center headed by Dr. Gary Bond at Indiana University Purdue University at Indianapolis. The center continues to provide regional training events, develop a web site, publish an ACT newsletter, provide job shadowing, and generally work with and assist the development of the ACT model.

We have defined Assertive Community Treatment in Indiana and we have promulgated the ACT rule. This process started with a meeting of the researchers with Dr. Bond's team, DMHA staff, providers, consumers and family members. The framework for the present rule was established at this meeting.

In 2001, we funded three ACT pilots and, in 2002, we funded eight additional pilot sites. This past year we have added four new sites, for a total of 15 pilot sites. One of the reasons for the development of the pilots was to gather data to determine the cost of ACT to determine the proper fundable levels for ACT.

Last June we finalized a Medicaid rate that will cover much of the costs of the ACT teams. This year we plan to add another five sites as pilots. It is anticipated that, with the new Medicaid rate, there will be more ACT teams starting. A recent survey indicated at least eleven programs intend to start new ACT teams and many existing sites will create additional teams.

There are seven pilot sites participating in the Dartmouth Integrated Dual Diagnosis Treatment (IDDT) tool kit. The ACT Center is providing the training and monitoring of these projects.

This office, in conjunction with the ACT Center, was successful in getting a SAMHSA grant to develop Illness Management and Recovery (IMR) at six sites. The second year application has been funded. The ACT Center is providing the training and monitoring of this project.

Supported Employment (SE) has been in operation in Indiana for ten years. The design of the Indiana SE program could easily be moved to fit the definition of an EBP, and we are exploring that concept. SE is discussed more fully later in this section.

The Indiana NAMI has been providing the Family to Family education series for several years. This is considered as part of the EBP Family Psycho-Education. This effort, funded by DMHA, is considered a move toward Family Psycho-Education.

Indiana is proud of the fact that we are providing four of the six EBP's and have a portion of a fifth. The challenge will be the continuation of pilot projects. ACT and Supported Employment are solidly in place. IDDT and IMR are newer and we are exploring the means to keep them viable. Family Psycho-Education would be a next logical step but is several years away from being more complete.

Available system of treatment, rehabilitation, and support services

All community providers are involved in rehabilitation and employment. However, not all are as formally involved in the provision of employment services, as are those with supported employment programs. While pleased with the growth in supported employment we are concerned with the decreasing numbers of persons with mental illness securing employment through supported employment programs.

In 1994 we closed a state hospital and had available state funds for the development of additional community based services. The DMHA and the Office of Vocational Rehabilitation (OVR) established a series of grants to create supported employment programs for those persons returning to the community from the closing hospital. This office was able to use the new state funds as match for federal funds available to OVR. That started the establishment grant series that was used to develop supported employment at 27 mental health centers.

At this time we have 24 mental health centers that are providing supported employment under a contract with OVR. There have been promising indications of late that show an increased interest in establishing supported employment teams. The ACT rule mandates that there be a supported employment program present and that there be an employment specialist on the ACT team. Whatever the reason, there are at least four providers that are either returning to supported employment or will be developing new supported employment programs this year.

As we began the establishment grants, we used the same funding arrangement with OVR to fund the Supported Employment Consultation and Training Center (SECT) at the Center for Mental Health in Anderson, Indiana. The SECT center is a provider of technical assistance to providers interested in developing or improving supported employment efforts. This Center continues to be very active

in providing training to the newly funded supported employment projects. One added component of the grant is data collection. This consists of collecting information on the numbers of persons entering supported employment, their wages, costs of supported employment counseling, the average time worked, the average wage, benefits and many other areas.

DMHA continues working with a committee that is exploring supported education. That effort lags behind the supported employment success but surveys of consumers, providers and educators indicate there is potential for expansion in this area. The OVR is interested in this project and has been involved in the committee work.

In 2001, legislation was passed that changed the Indiana Medicaid rules to allow for a Medicaid buy-in program. This program called MEDWorks will enable persons with a disability to pay a premium to Medicaid based on their monthly income to help offset the cost of the program. As we anticipated, there was an increase in the numbers of people who want to work. They no longer need fear loss of Medicaid and many now working at lower pay levels will be able to accept a pay increase, promotions and additional hours.

For a number of years we have compared the differences in the percent of consumers employed between agencies with and without supported employment. The state planning council decided to begin tracking changes in the numbers of consumers employed. That data are reflected in the goal for this criterion titled "Employed".

There has been a steady decrease in the numbers of people that have been successfully closed in supported employment. This is of some concern and it is now a priority of FSSA to increase the number of successful closures by 15%.

#### Description and definition of case management system

Case management services are goal oriented activities that assist individuals by locating, coordinating and monitoring necessary care and services appropriate and accessible to the recipient. The major components of service are essential to reducing handicaps or disabilities resulting from the impairment of the person served. Back up support for this service is to be available 24 hours per day. Any individual who meets the definition of having a serious mental illness is eligible for case management.

Indiana Code includes the following definition of case management services in Chapter 19 "Community Care for Individuals with Mental Illness".

"Sec. 2. (a) As used in this chapter, "case management" means goal oriented activities that locate, facilitate, provide access to, coordinate, or monitor the full range of basic human needs, treatment and service for individual patients.

- (b) The term includes where necessary and appropriate for the patient the following:
  - (1) Assessment of the consumer.
  - (2) Treatment planning.
  - (3) Crisis assistance.
  - (4) Providing access to and training the patients to utilize basic community resources.
  - (5) Assistance in daily living.

- (6) Assistance for the patient to obtain services necessary for meeting basic human needs.
- (7) Monitoring of the overall service delivery.
- (8) Assistance in obtaining the following:
  - (A) Rehabilitation services and vocational opportunities.
  - (B) Respite Care.
  - (C) Transportation.
  - (D) Education Services.
  - (E) Health supplies and prescriptions."

We have also established a rule for the provision of case management. The rule covers in detail the minimal standards for the provision of case management by the mental health centers. The rule is inclusive of the mandates of the above law and provides more measurable components and eliminates much of the areas that were open to interpretation under the law alone.

Historical reduction of state hospital beds changes in utilization of psychiatric inpatient in other settings

This year marks the tenth year of the closing of Central State Hospital, located in Indianapolis. The state funds used to operate that institution were moved to support community based services. To evaluate the effects of this closure, this office funded research to track all of the individuals who were at that hospital at the time of the closure. This research is measuring many quality of life issues and the researchers have maintained contact with nearly all the 400 individuals in the hospital at the time of its closing. In addition, the research is tracking former employees of the hospital to examine the effect of the closure on them. There have been regular reports by the researchers including annual reports on the data collected. A series of articles based on the data collected appeared in *The Journal of Behavioral Health Services & Research*, August 1999, Volume 26/Number 3. This research project has now ended with the tenth anniversary of closure and final reports are due later in state fiscal year 2005.

The Division examined the utilization of state hospital beds by the mental health centers and it became apparent that there was inequitable use. To make access to the state operated beds more equal a system of bed allocation was established whereby each mental health center is assigned a number of beds based on the population served by each center.

The DMHA is presently re-examining the means by which we are measuring outcomes. The present process is very detailed and time consuming for both the provider and consumer. There are several models being considered and these will not be in place until state fiscal year 2006.

Description of Substance Abuse Services for Adults with Serious Mental Illness

While all mental health centers are providers of substance abuse services, not all have developed integrated programs for the severely mentally ill substance user. A survey of providers indicated that 14 of the 30 providers have an identifiable dual diagnosis track for consumers.

Indiana is involved in the Dartmouth Dual Diagnosis tool kit project. We are working with the Technical Assistance Center at Indiana-Purdue University at Indianapolis on this project. Seven mental health centers have agreed to be part of the project and will be establishing integrated

services for the dually diagnosed according to the tool kit. One of the concerns about this is the ability of DMHA to create a funding stream that is dedicated to the support of IDDT.

#### Housing

The mental health centers, as a requirement of the Continuum of Care, are responsible for residential services. Some have been very active in securing HUD financial assistance to develop a range of residential options. Some have been awarded Shelter Plus Care grants. This office has had a number of events to encourage the providers to be better able to seek funding. We have taken steps to insure that providers participated in the Consolidated Plan and in the Continuum of Care application. There are plans to increase the number of providers requesting HUD funding next year in the Balance of State application.

Housing continues to be a major concern for all providers. This office shares that concern and we have developed a Housing Action Team that is examining the existing housing options and examining ways to assist providers in creating more housing options.

#### Medical and Dental services

Mental health centers are required by rule to complete a physical health screen with referral for a physical examination when clinically indicated. Additionally, in the normal course of treatment the consumer often asks for assistance in securing any medical or dental assistance. For residential care the rule states that the agency must assist the resident to obtain medial and dental care.

#### Cultural Competence

The Division of Mental Health and Addiction recognized the need for service providers to develop cultural competencies in programs and staff. In 1997, the DMHA entered into a contractual agreement with a training agency to provide statewide Cultural Competency training for mental health and addiction providers. The training is designed to help service providers improve mental health and addiction treatment outcomes for the various cultural groups within the service regions. The training project approaches cultural competency from a system perspective and addresses critical issues such as client retention, treatment approaches, community involvement and staff skill development.

The Cultural Competency Enhancement Project has been successful in addressing Cultural Competency issues for providers statewide. During the past year there have been 255 individuals that attended Cultural Competency training courses. There were 121 individuals representing 44 agencies at the annual conference, "Bridging Cultures with Competence".

#### Office of Consumer and Family Affairs

In the amendment of the 2000 Block Grant Plan, this office decided to use the increase in Block Grant funds to establish an office of consumer affairs. That position remains and has proven to be an asset to this office. The position started as a contract position but has now moved to a state position. The purpose of the Office of Consumer and Family Affairs is to empower consumers and family members by assuring their interests are represented and their input is considered in DMHA planning and policy development.

The goals for the Office of Consumer and Family Affairs for the coming year are:

- 1. To provide an "internal" voice for consumers and family members within DMHA.
- 2. To liaison with consumer and family organizations to establishing communications, identify major issues and concerns, and provide consultation, technical assistance, and ongoing support.
- 3. To develop, implement and monitor special projects, including a minimum of six annual focus groups to solicit consumer input on Olmstead planning and implementation.
- 4. To identify, train and involve a minimum of twelve consumers and family members annually in DMHA planning and policy development activities.

### Services for the Elderly

We began tracking services for the elderly two years ago, and now we are also tracking independent living for the elderly as reported on our client data system. This year a presentation on projections of the impact of the aging population on the mental health system was made by two members of this office to a group of providers specializing in elderly services. We have noted some issues in elderly services that are national trends as well. The numbers of elderly drop significantly in our services. As one writer put it, it appears that there is a magic cure for mental illness at age 60 because there are so few in treatment in mental health centers above that age.

# Recent Planning Council recommendations

At the August 20<sup>th</sup> meeting of the Planning Council several issues were raised that will be included in the planning council letter that will not be incorporated into this year's plan as goals. These are listed here so they will be formalized as part of the narrative of the plan.

- Consumer involvement will be explored further. There is a survey instrument available but fiscal limitation may make it impossible to do the survey this year.
- Peer Support Services will continue to be encouraged by this office. Further discussion on this issue will take place during the year.
- Waiting lists for community services will be surveyed by this office to determine the size
  and impact of waiting lists. Crisis care is not delayed and people in crisis are seen
  immediately regardless of a waiting list. If it is discovered that the waiting lists are a
  problem they will be listed as a gap or weakness and goals will be developed in future
  plans.
- The issue of delays in authorization by vocational rehabilitation has already been addressed in meetings with OVR. Their data system is capable of tracking authorization time and this office and OVR intends to use this data tracking to identify the slower offices and begin to decrease authorization time.
- The exploration of other employment resources for persons with mentally illness has already started and will be continued. There was a lack of information in this area provided to the planning council and that will be remedied.

# Strengths:

- Statewide coverage
- Defined Continuum of Care
- Defined case management
- Office of Consumer Affairs
- Evidence Base Practices
- Moving to outcome measures
- Strong history of supported employment
- Gatekeeper model and bed allocation

#### Weaknesses:

- Do not have strategy to fiscally continue EBP's
- "Outside" admissions to the state facilities is limiting the number of beds available to the community provider.

# **Criterion 2**

# **Estimations of Prevalence and Mental Health Systems Data**

Quantitative population targets to be achieved through implementation of the mental health system including estimates of numbers of individuals with SMI in the state and the numbers of such individuals served.

#### State Definition of SMI

Indiana Administrative Code (440 IAC 8-2-2) provides the definition of adults with serious mental illness as follows:

- A) The individual is eighteen (18) years of age or older.
- B) The individual has a mental illness diagnosed under the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition, published by the American Psychiatric Association.
- C) The individual experiences significant functional impairment in two (2) of the following areas:
  - i) Activities of daily living
  - ii) Interpersonal functioning
  - iii) Concentration, persistence, and pace
  - iv) Adaptation to change
- D) The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, adults who have experienced a situational trauma do not have to meet the durational requirement of this clause.

This definition closely parallels the federal definition of serious mental illness and for purposes of reporting data regarding persons served in Indiana is considered equivalent.

#### Description of Estimation Methodology

The Division of Mental Health and Addiction uses two methodologies for estimating the prevalence of adults with Serious Mental Illness in Indiana. The first method is calculated using

the Center for Mental Health Services methodology. The second method is based on the eligibility requirements for the Hoosier Assurance Plan, which established eligibility at or below 200% of the federal poverty level.

<u>Center for Mental Health Services Methodology</u>—Based on the *Federal Register* "final notice" of June 24, 1999: Estimation Methodology for Adults with Serious Mental Illness (SMI), the prevalence for Indiana children with Serious Mental Illness is depicted in the following table.

<u>Population Prevalence Estimates at 200% FPL</u> — The total number of adults aged 18 and above in Indiana based on projections from the 2000 census will be approximately 4,648,737. Also based on the 2000 United States Census reports, approximately 26% of Indiana's adult population has incomes at or below 200% of the federal poverty level.

The following table depicts the prevalence of adults with mental illness in Indiana based on the two estimation methodologies.

#### INDIANA ADULTS WITH SERIOUS MENTAL ILLNESS

Eligible for DMHA Services	66,129
CMHS Estimation Methodology	251,032
2005 Indiana Population aged 18 and above	4,648,737

# Strengths:

• Numbers of persons served has been increasing each year.

#### Weaknesses:

• There has been no proportional increase in funding in response to the increased number of persons served.

# **Criterion 4**

**Targeted Services to Homeless Populations Targeted Services to Rural Populations** 

Description of the homeless population

Estimates provided in the Indiana Continuum of Care indicated that there are 58,000 homeless in Indiana. Of these, it is estimated that one third or 19,000 homeless individuals have a mental illness.

#### Description of available services

The client based data collection provides information on living situation that includes homelessness. All of the mental health centers report on services to the homeless population.

# Description of PATH, Shelter Plus Care, and HUD grants

The Indiana Family and Social Services Administration's Division of Mental Health and Addiction contracts with ten mental health centers to provide Mobile Homeless Outreach Teams through the PATH Grant Program. The teams are located in the most densely populated areas of Indiana: Central Indianapolis, Fort Wayne, Lake County (two centers), South Bend, Elkhart, Bloomington, Evansville, Anderson and Muncie. The PATH grant was increased this year and we will be adding a new team.

The teams provide the following services:

- Screening and diagnostic treatment services
- Habilitation/rehabilitation services
- Community mental health services
- Staff training
- Case management services
- Supportive and supervisory services in
- Residential services
- Referrals for primary health services,
- Job training and educational services
- Housing services

Since all these teams are a part of comprehensive community mental health centers, the full continuum of services are available to persons who are homeless that are enrolled in treatment services.

The target population for the Mobile Homeless Outreach Teams is the homeless individual who is mentally ill and has problems that require professional intervention. Homeless has been defined as including individuals who:

- 1. May live on the street, in cars, or in abandoned structures or public places;
- 2. Are housed in emergency shelters and other places not considered home:
- 3. Are living with friends or relatives in crowded, unhappy, and stressful circumstances;
- 4. Are living in deteriorated, unsafe housing, often lacking utilities; or
- 5. Are involved in support programs without which they would be at high risk of homelessness.

Some of these individuals may be "chronic" street people while some are on the streets on an episodic basis.

As part of the PATH grant application this office developed a definition of the "at-risk of homeless population".

"A person at imminent risk of becoming homeless includes those who are:

- living with friends or relatives in a sequence of living arrangements
- living in a condemned building
- facing an eviction notice
- in a county jail with no housing available upon release
- in a psychiatric inpatient unit with no housing available upon release"

Per the requirements of the HUD super NOFA this office created a new policy that clarified the prohibition on discharging individuals from state operated mental health hospitals to homelessness. That policy was reviewed and approved by the DMHA Policy Development Committee and distributed to all applicable agencies.

Shelter Plus Care has been successfully funded at six mental health centers. Park Center in Ft. Wayne and Midtown in Indianapolis are in the second funding phase. The Lawrenceburg project and the East Chicago site have applied for continuation this year. In addition, there were three new applications made for Shelter Plus Care this year.

While developing the Indiana Continuum of Care, this office agreed that all providers should have a service agreement with their local homeless shelter. This office surveyed all providers to determine the presence of an agreement with the local homeless shelter. The results of that survey showed that all mental health centers have an agreement with local shelters where there are shelters.

The Indiana Housing Finance Authority has been sponsoring the Interagency Council (IAC) comprised of the highest level decision-makers from state agencies involved in homeless issues. The IAC has membership of the Housing Finance Authority, Department of Correction, Department of Veterans Affairs, Department of Health, and two offices of Family and Social Services Administration: the Division of Family Resources; and the Division of Mental Health and Addiction.

A subcommittee of the IAC attended *Improving Access to Mainstream Services for People Experiencing Chronic Homelessness*, a Policy Academy for State and Local Policymakers, in Chicago. As a result of that event the subcommittee is developing an Indiana plan to end Chronic Homelessness. That plan is now in the final stages of approval by the IAC and will be distributed this year.

Definition of rural locations in the state and description of the urban/suburban/rural mix The Division has established a definition of rural: those counties with fewer than 100 persons per square mile.

As a result of the census of 2000, we remain a rural state but we have changed from 62 to 61 rural counties. The number of people living in rural counties has slightly increased by 0.64% (1,545,000 to 1,555,000) while the whole state increased by 9.7% (5,544,000 to 6,080,000). The percentage of people living in rural areas has changed from 27.8% to 25.6%.

During the review of the 2001 Block Grant application the reviewers were interested in how Indiana managed such high rates of penetration in rural areas and suggested this office provide

some insight into that. This office did a survey of rural providers and several rural providers were interviewed to discuss the success of rural providers in the area of outreach and engagement of consumers in rural areas. Some providers are very active in the school systems, providing therapists who work with children. Most have increased the number of case managers. All seemed to have excellent relationships with local DFR offices and law enforcement. It became clear that the rural mental health centers are one of the major employers in the community and the rural providers have a higher level of standing and recognition in the community than do the urban providers. One provider commented that they have established auxiliary offices so that there is an office within 30 minutes of everybody in the service area. All interviewed said they had a high level of coordination with other service providers in the area.

This office is very proud of the rural coverage that exists. For the past several years we have monitored the levels of service in rural areas and found that penetration rates are virtually the same in rural areas as in urban areas.

#### Strengths:

- Increased PATH funds have made it possible to add new teams or increase funding to existing teams.
- Rural coverage has been comparable to urban services.

#### Weaknesses:

 The numbers of homeless reached is very low compared to the estimated numbers of mentally ill homeless.

# Criterion 5

# **Management Systems**

Financial and staffing resources...which will be needed to implement the plan. Must show how we intend to expend the block grant for FY 2005.

The majority of the Block Grant funds are placed in the general treatment funding pool of DMHA. Funds are distributed to providers through a funding allocation formula based on levels of services from the previous year. This system does not allocate Block Grant funds proportionally. At the end of the contract year we are able to track funding sources for each contactor so that we are able to show where Block Grant funds were expended.

The following table represents the various funds available for the purchase of services for the SMI population. Not shown on this table are the Medicaid Rehabilitation Option (MRO) funds that the providers will be able to access during the year. The billing for MRO will be over \$180 million again this year.

The state budget forecast is not promising and we do not anticipate any increases in state funding this year. In fact, Indiana is looking at deficits for state fiscal years 2005 through 2007. At this

time we are uncertain about possible budget reductions and we will continue to advocate for no reductions in community mental health funding. As with past budget reversions, we will protect treatment funds by reducing non-treatment budget areas.

# Comparison of DMHA Funds for Mental Health Centers for SMI Services State Fiscal Year 2002 to 2004

	Adult Services	Social Services Block Grant	Mental Illness Block Grant	TOTAL
SFY 2002	\$75,611,322	\$3,938,678	\$3,000,000	\$82,550,000
SFY 2003	\$75,855,836	\$3,694,164	\$3,000,000	\$82,550,000
SFY 2004	\$75,984,704	\$3,565,296	\$3,000,000	\$82,500,000

Description of the role of the MHBG program in the state, including innovative services funded by the grant.

The block grant funds, for adult services, are used for the purchase of community based services provided by the mental health centers.

While not directly related to the block grant funds, this office is also funding the KEY Consumer Organization for the development of advocacy groups and NAMI Indiana for the purchase of Family to Family training for families and others involved or affected by mental illness. This office also funds a strong research component through Indiana University that is researching the closure of our state hospital. We also fund the ACT Center that provides technical assistance and training for the developing ACT teams.

#### Emergency Health providers

All providers have a close relationship with local emergency providers. In some instances there is staff from the mental health center at the hospital emergency room to assist in evaluations. One provider noticed problems with law enforcement and the transportation of individuals to court. They trained a small group of law enforcement officers who now volunteer for transportation duty. This has reduced the trauma of such transportation. Another provider, more than 15 years ago, started training local law enforcement and emergency responders following an airplane crash in their area. Several agencies have adopted the Memphis model. There are also providers that have established mobile crisis units that respond with law enforcement when called on a disturbance involving a potentially mentally ill individual.

Emergency response personnel receive training from the State Emergency Management Agency (SEMA). SEMA contracts with a community mental health center to provide training for emergency response personnel in Crisis Counseling Intervention techniques. Since 9/11 the Governor created the Heartland Security Agency (HSA) for Indiana, to respond to terrorist activities that may affect citizens, business, and government activities.

There is a cooperative agreement between the Indiana Department of Health (ISDH) and the Centers for Disease Control and Prevention (CDC) that recognizes the requirements to address needs and direct activities to issues of psychological health and their behavioral manifestations. The Division of Mental Health and Addiction, in partnership with the Indiana Department of Health is responsible for administering the State's program for the psychological health of those Indiana residents potentially victimized by emergencies and disasters to include acts of terrorism involving weapons of mass destruction. The CDC Public Health Preparedness and Response for Bio-terrorism Program Announcement 99051 provides to the Division of Mental Health and Addiction through a sub-grant from the Indiana State Department of Health, specific funding to assist the State with developing and validating plans for Mental Health Services.

The Indiana Division of Mental Health and Addiction has developed the *All-Hazards Emergency State Plan* as a mental health and addiction emergency management standard for the State of Indiana. This All-Hazards Emergency State Plan has been developed in conjunction with the State of Indiana Comprehensive Emergency Management Plan.

The *All-Hazards Emergency State Plan* is a State-level management tool that will support the standard operating procedures of all participating community mental health centers and contracted Division of Mental Health and Addiction mental health and addiction providers. Written procedures will be developed by each of the 31 Community Mental Health Centers, which serve all 92 Indiana counties and will support the Counties Comprehensive Emergency Management Plans.

The community mental health centers or the designated mental health or addiction agency will be responsible to update and provide mental health response plans to the local emergency management agency director. These plans will focus on providing crisis counseling and other mental health and addiction services for a community response before, during, and after an emergency or disaster, including acts of terrorism.

Plans to reallocate resources or expand funding to community-based services

This office has a history of moving state hospital funds to the community to increase community based funding. With the closure of one state hospital and the reduction of beds in the remaining hospitals we have reached a stage where further reductions are difficult. We continue a funding arrangement in which mental health centers are paid to remove people from the state hospitals and maintain them in the community. This is designed to return patients with more than two years of hospitalization to the community. The Long Stay Patient Transition Study is tracking nearly 300 people that have been returned to the community under this project.

# Section II. – Children's Mental Health System Identification and Analysis of the Service System's Strengths, and Needs and Priorities

# Criterion 1

# **Comprehensive Community-based mental health services systems**

Organizational structure of the system

Publicly funded children's mental health services in Indiana are financed through four different state agencies, each with different eligibility requirements. Medicaid is probably the largest purchaser of services through Hoosier Healthwise, and the more recent SCHIPS program. The Division of Family and Children funds services for CHINS (children in need of services) through county Offices of Family Resources, governed largely by the local county judiciary. The Division of Exceptional Learners of the Department of Education (DOE) provides funding for intensive services to youth who cannot be educated using existing local resources. Approximately 45% of the students have been determined eligible for special education on the basis of an emotional disturbance. Youth remanded to the Department of Correction (DOC) are sometimes placed in residential care using correction funding. Finally, the Division of Mental Health and Addiction (DMHA) funds services through a network of providers, which are primarily but not exclusively, community mental health centers (CMHCs). About 55% of the DMHA budget is for community based program (\$179 million): \$16 million or about 10% of the community budget is targeted for children with SED at or below 200% of poverty.

Children are served by the Division of Mental Health and Addiction through one of 31 Community Mental Health Centers or other contracted care providers, with multiple locations thought the state. Children are assessed with the Hoosier Assurance Plan Instrument for Children (HAPI-C), and income eligibility is determined based on a family income at or below 200% of the Federal Poverty Level (FPL). The HAPI-C measures the child's level of functioning and self-management skills relative to the child's appropriate development. The Hoosier Assurance Plan is designed to equalize the availability and quality of community-based mental health and addiction services across the state for those most in need with an array of mental health services The goal of the Hoosier Assurance Plan is to assure community-based living. Level and intensity of services provided are determined though the development of an individualized treatment plan.

Each CMHC reaches a primary service area so that there is adequate statewide coverage. In 1999, state legislation established the CMHC's as gatekeepers for the state psychiatric hospital system, fostering collaboration between the CMHC and the hospital. Subsequent law expanded gatekeeping responsibilities to include monitoring of the hospital stay, case management duties, discharge planning and follow-along services. Face to face quarterly meetings with the consumer are required.

Community Mental Health Centers and other providers are required to provide a range of services for children. Indiana Administrative Code defines the populations to be served, the continuum of care, and minimum standards for the provision of services. Minimum standards for the following components of a continuum of care were defined in state fiscal year 2002-2003:

case management, outpatient services, medication evaluation and monitoring, and family support.

The continuum of care assures adequate services for youth with substance abuse and/or cooccurring mental health issues. Services range from substance abuse education to intensive out
patient programs. DMHA is providing leadership in moving toward integrated treatment for
youth with mental health and substance abuse by arranging presentations on the latest findings.
During August 2004 SAMHSA staff conducted keynote addresses and workshops at two
statewide conferences regarding the latest research in adolescent substance abuse treatment. A
statewide provider/consumer conference is being considered. Should our recently submitted
State Incentive Grant be funded, Indiana will begin to implement an Evidence-Based Practice for
substance abusing youth, the Cannabis Youth Treatment (CYT).

Three state hospital units serve children. A fourth children's unit was closed in 2002. State hospital capacity for children is 90 beds. One of the units serves adolescent males, another serves children 5 through 12 and the third serves all youth and both genders. The facility serving younger children seldom reaches capacity. Each year, for the past three years, the number of children served has declined. During state fiscal years 2001-2003 targeted transitional funds were used to transition youth back to the community. In state fiscal year 2004 those funds were applied to the Home and Community-based Waiver for children with serious emotional disturbance. We are working on ways to track the rate of re-admission to hospital care through the Community Mental Health Centers.

#### Available system of treatment, rehabilitation and support services

Since the mid-1990's children's Systems of Care (SOCs) have developed throughout the state to serve children with serious emotional disturbances. Some were supported by state funds and others through community efforts. Beginning in 2000, DMHA offered seed funding for newly developing SOCs. At the beginning of state fiscal year 2005 there are 32 SOCs, including 2 federally funded sites. Half of Indiana counties are served by SOCs. During state fiscal year 2004, 639 children were enrolled in SOCs. Indiana's SOCs are nurtured by the state-funded Technical Assistance Center for Systems of Care and Evidence-Based Practices for Children and Families (TAC). The TAC offers ongoing, onsite coaching and consultation for SOCs, as well as regional trainings, an annual conference, website, list serve and quarterly newsletters.

In February, 2004 Indiana was awarded a Home and Community Based Medicaid 1915 (c) Waiver (HCBS/SED). The state matching funds were braided from Department of Correction (DOC), Department of Education (DOE), State Medicaid and DMHA. The waiver is in its early implementation stage. It will serve 50 youth in its first year, and 200 by the third year. An Institutional Level of Care (LOC) instrument was adopted for children with serious emotional disturbances. This instrument is used to determine eligibility for the Home and Community-based waiver or admission to a state psychiatric hospital or for return to the community from the hospital. The instrument is used by the CMHC gatekeepers. It was developed through a year-long process that included active participation of families, providers and state psychiatric hospital personnel.

Consumer choice for SED children and their families has been expanded with the approval of the HCBS waiver. The menu of possible services includes:

- Case management/wraparound facilitation: assessment of the child's and family's strengths
  and needs to determine services needed from the community based waiver and non-waiver
  services. The community-based plan identifies specific goals, objectives, responsibilities
  timeliness, outcomes, performance measures, and costs. It emphasizes collaboration and
  coordination among family, caretakers, service providers, educators and other community
  resources.
- Family support and training: assisting and coaching the family to increase their knowledge and awareness of the child's needs, the process of interpreting choices offered by service providers, explanations and interpretations of polices, procedures, regulations that impact the child living in the community, and behavioral management training.
- *Independent living skills*: assist children and adolescents in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.
- Respite care: short term and temporary direct care and supervision for youth. The primary purpose is to relieve families/caretakers of a child with a severe emotional disturbance so that the caretakers can participate in activities that may not be accessible or acceptable for the child

The service needs of Indiana's children and youth are addressed by a multiplicity of programs and community-based entities. The Indiana Department of Education provides an array of mental health services to students with an emotional disability through the Division of Special Learners and IDEA program. Increasing numbers of school districts offer wraparound services for their students.

Children's Services supported by the Division of Family Resources/Department of Child Services include: First Steps Early Intervention (part C), Title IV-E waiver program, TANF, Independent Living, Safe Housing-Runaway program, alternative living, preventative health care, child care services, parenting skills and child protection and placement services.

The Indiana State Department of Health (ISDH) collaborates with DMHA in crafting the mental health component of the state's children's health plan. They offer a program for children with chronic health conditions, and links with First Steps (part C) through the Children's Special Health Care Program. DMHA has served as a core partner with ISDH in its planning grant, awarded by Division of Maternal and Child Health, for Early Childhood Comprehensive Community-based Systems.

The Office of Medicaid Policy and Planning supports primary medical and mental health services and dental services for children. They have been successful in securing the 1915 (c) Home and Community-based Waiver for children enabling SED youth to have the option of community-based care rather than hospitalization.

The Division supports access to psychiatric consultation to hospitalized children and their families who are being treated for acute and serious medial problems at the Indiana University School of Medicine's children's facility, Riley Hospital. This service makes available a level of consultation often not accessible in the family's community.

During 2004 the Division's Office of Consumer Affairs offered services through participation in statewide Systems of Care meetings, consultation with newly forming family support groups and conducting many community presentations.

Under state contract, the Indiana Federation of Families for Children's Mental Health (IFFCMH) will conduct a statewide conference in conjunction with other support organizations. This inaugural conference will give an opportunity to newly forming family support organizations, and Systems of Care family participants, to learn from experienced organizations. The Federation will offer on site consultation for interested groups, improve youth participation and serve as an information source for family/youth involvement.

The purpose of the Hoosier Assurance Plan Provider Report Card is to organize and publish information on public mental heath services for consumers and their families. The upcoming annual report will display information received from a telephone survey of family members of children. The survey asks questions about access, participation, rights and satisfaction with services. The survey instrument is the Youth Services Survey for Families.

DMHA is represented on the Governor's Interagency Coordinating Council for Infants and Toddlers, the state's Step Ahead and Head Start Panels and contributes a monthly column for all Head Start providers. DMHA has, for the past two years, convened a Community Capacity Committee composed of a variety of child serving state and private agencies for the purpose of cross-systems collaboration toward shared goals.

#### Strengths

Community Mental Health centers and providers are required to provide a range of services for children. Indiana Administrative code defines the population to be served, the continuum of care and sets service standards. The continuum includes case management, outpatient services, medication evaluation and monitoring, and family support. Contracts with providers assure Indiana children have access to mental health and addiction services anywhere in the state. With the development of Systems of Care, approximately 75% of the state's youth populations live in the 32 areas served by a System of Care. The 1915 (c) waiver offers community-based care to children who would otherwise be admitted to a state psychiatric hospital. Funding for the waiver has been braided from Department of Corrections, Medicaid, Department of Education and DMHA. Indiana's commitment to keeping children in their communities can be tracked with reduction of admissions to state hospitals during the past two years.

A study to assess local systems of care from stakeholder group perspectives (parent/family member/consumer, education, Division of Family Resources, juvenile justice and mental health) was conducted under contract with DMHA. It was learned that second and subsequent waves of system of care systems funded through DMHA were perceived to be more effective than earlier ones.

#### Weaknesses

We continue to serve more children, despite a reduction in funding. This year we served 9% more children than in the previous year. The year prior, we served a 14% increase. This could be construed as strength, but there is a limit. Providers are given a specific amount when a child is

enrolled; most providers continue to enroll children long after their DMHA award has been expended. Although 78% of children served in 2004 were covered by Medicaid at the time of enrollment, 22% were not, leaving a significant gap in coverage for providers to fund. The community mental health centers are struggling to balance increasing demand with limited resources. State funds allocated to the centers are first used as state match for the federal portion of Medicaid. As more children enter the system with Medicaid funding, fewer dollars are available for services to non-Medicaid indigent children.

A recent study of the state's budget for children's services revealed that out of a \$1.5 billion budget, 1% was allocated to children's mental health. When Medicaid reimbursements were added, the total rose to 7%.

#### Unmet needs/gaps

Based on estimated prevalence rates, for the designated DMHA child population, at least 10,000 youth may not be receiving services. If we expand estimates to include all Indiana children believed to be in need of mental health services, regardless of income, 138,000 children are not being served.

We do not have appropriate services for many transition points, such as: from institutions to the community, from child to adult services, or from one system to another. The growth in Systems of Care has somewhat expanded the capacity to deal with a limited number of transition challenges, but the need far exceeds the capacity.

The dually diagnosed population is not being well served. There is little cross system coordination between service systems for persons with developmental delay or with mental retardation and children with serious emotional disturbance. Lack of access to the respective data centers for these separate systems creates a major challenge for outcomes measurement.

# Criterion 2

# **Mental Health System Data Epidemiology**

State Definition of SED

In Indiana the Division of Mental Health and Addiction considers children to encompass birth through 17 years of age. The implemented definition of SED is as follows:

- 1. The child has a mental illness diagnosis under DSM IV.
- 2. The child experiences significant functional impairments in at least one of the following areas:

Activities of daily living,

Interpersonal functioning,

Concentration, persistence and pace,

Adaptation to change

3. The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, children who have experienced a situational trauma, and who are receiving services in two or more community agencies, do not have to meet the duration requirement of this clause.

This definition closely parallels the federal definition of serious emotional disturbance and for purposes of reporting data regarding persons served in Indiana is considered equivalent.

# Description of Estimation Methodology

The Division of Mental Health and Addiction uses two methodologies for estimating the prevalence of children with Serious Emotional Disturbance in Indiana. The first method is calculated using the Center for Mental Health Services methodology. The second method is based on the eligibility requirements for the Hoosier Assurance Plan, which established eligibility at or below 200% of the federal poverty level. The following tables provide both calculation methodologies.

TABLE 1

		Level of functioning at 50		Level of functioning at 60	
Number of youth 9-17 (2005)	Percent in Poverty (2005)	Lower Limit 5%	Upper Limit 7%	Lower Limit 9%	Upper Limit 11%
1,624,393	10.20%	81,220	113,707	146,195	178,683

TABLE 2

# INDIANA CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE 2005

Eligible for DMHA Services	32,334
GAF <50	97,464
GAF <60	162,439
2005 Indiana Population aged 0 - 17	1,624,393

#### Strengths/weaknesses

The Hoosier Assurance Plan (HAP) directs public funding to those individuals in greatest need of mental health services. HAP is designed to equalize the availability and quality of community-based mental health and addiction treatment with an individualized array of services. During state funding year 2004, 75% of children estimated to be in need of, and eligible for state-funded services (living in families earning less than 200% of the Federal poverty level), received public mental health services. Given diminished funding, this is a strength because it demonstrates that providers are serving children for whom they do not receive DMHA reimbursement. It is also a challenge, because there are more children needing services who do not receive them and funding for the system is not increasing concurrently with increases in numbers being served.

The Mercer Government Human Series Consulting group concluded during a 2004 study that the HAPI-C (children's assessment tool) is consistently the most powerful risk predictor.

# **Criterion 3**

#### Children's Services

The Family and Social Services Administration's Division of Mental Health and Addiction (DMHA) is the state mental health authority. The Division advocates for the needs of persons in the target populations; establishes policy for funding and evaluation of community-based mental health and addiction treatment providers; establishes policy for and funding of a system of substance abuse prevention projects; establishes rules for the regulation of mental health providers; and manages a system of state psychiatric hospitals.

During state fiscal year 2005, DMHA will allocate block grant dollars in accordance with requirements identified in Section 1911. Stipulations are written in the contracts of each certified and approved managed care provider of SED services.

The entire state is identified as the geographic region for block grant coverage. The identified service areas of the 25 providers of children's services cover all of Indiana's 92 counties. The state map on the following page identifies providers and their primary service areas.

#### Substance Abuse Services

Approved providers for SED children are required to offer substance abuse counseling and treatment for children dually diagnosed with SED and substance abuse and addiction. Addiction providers must assess the need for mental health services, and if appropriate make referral for such services. In concert with various provider groups, we are exploring best practices in integrating substance abuse/mental health services for adolescents. SAMHSA has presented compelling research about more effective ways to treat dually diagnosed youth, which have been disseminated through conference presentations.

#### Comprehensive Community Based Care Development

The Division partners with many state and local agencies that serve children. It encourages providers with whom it contracts to expand mental health services to children and families who are referred from child welfare, the schools, the juvenile courts and others. State mental health legislation identifies a continuum of care that emphasizes services being provided in the community.

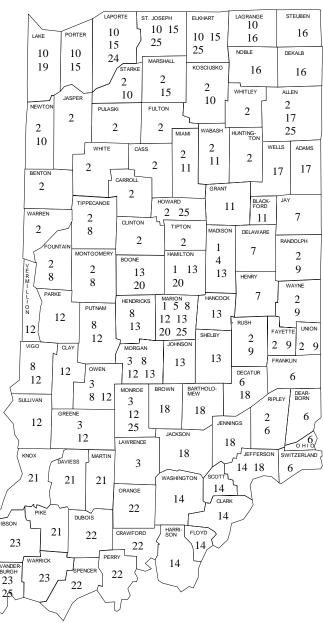
The Office of Medicaid Policy and Planning (OMPP) support primary medical and mental health services and dental services for eligible children. They have been successful in securing a 1915 (c) Home and Community-based Waiver for children enabling SED youth to have the option of community-based care rather than hospitalization.

# Family and Social Services Administration DIVISION OF MENTAL HEALTH AND ADDICTION Geographic Areas Served by Providers for Children's Services SFY 2004

- Addiction Resource Network of Indiana Indianapolis, IN 317-876-6660
- Affiliated Service Providers of Indiana Logansport, IN 574-722-5151
- Center for Behavioral Health Bloomington, IN 812-339-1691
- 4. Center for Mental Health Anderson, IN 765-649-8161
- Children's Bureau of Indianapolis Indianapolis, IN 317-264-2700
- Community Mental Health Center Lawrenceburg, IN 812-537-1302
- Comprehensive Mental Health Services Muncie, IN 765-288-1928
- Cummins Mental Health Center Avon, IN 317-272-3330
- Dunn Mental Health Center Richmond, IN 765-983-8000
- 10. Geminus Merrillville, IN 219-757-1905
- Grant Blackford Mental Health Marion, IN 765-662-3971
- 12. Hamilton Center Terre Haute, IN 812-231-8323
- InteCare (Adult & Child, Gallahue, Midtown, BehaviorCorp) Indianapolis, IN 317-237-5770
- LifeSpring Mental Health Center Jeffersonville, IN 812-283-4491
- 15. Madison Center South Bend, IN 574-234-0061
- 16. Northeastern Center Kendallville, IN 260-347-4400
- 17. Park Center Fort Wayne, IN 260-481-2721
- 18. Quinco Behavioral Health Columbus, IN 812-379-2341

23

- Saint Margaret Mercy Hammond, IN 219-932-2300
- 20. Saint Vincent Hospital Indianapolis, IN 317-338-4600
- 21. Samaritan Center Vincennes, IN 812-886-6800
- 22. Southern Hills Counseling Jasper, IN 812-482-3020
- 23. Southwestern Indiana CMHC Evansville, IN 812-423-7791
- 24. Swanson Center Michigan City, IN 219-879-4621
- 25. Villages of Indiana, Inc. Indianapolis, IN 317-273-7575



The Indiana Department of Education, through its Division of Special Learners, has committed financial support of the Medicaid waiver for a limited number of children under its auspices. The Division of Special Learners is an active participant in the Policy Academy delegation. They have assisted in the planning and implementation of the Early Identification and Intervention initiative (referred to as the child welfare screening). They also partner with DMHA in work with the Indiana Bar Association to address juvenile justice/mental health issues.

The Indiana Family and Social Services Administration's Division of Family Resources (DFR), in addition to provision of programs mentioned in Criteria I, is the pivotal participant in the child welfare screening. As part of Indiana's Family and Child Services Review in 2003, Indiana was sited to address its child placement failure rate. The Policy Academy delegates concluded that effective mental health screening of all children entering the child welfare system would be an appropriate response to the challenge. All local DFC offices will partner with their local Community Mental Health Centers (CMHCs) to create plans for performing the screening and assessments and subsequent treatment planning.

Juvenile Justice services are carried out through separate systems: county juvenile courts, county probation offices, 25 county-based detention centers and the Department of Correction, for incarcerated youth. There is no single Juvenile Justice authority in Indiana. The Department of Correction (DOC) offers mental health programs, as well as community reintegration pilots. Juvenile Courts and probation departments provide diversion and treatment programs. Detention Centers contract with mental health service providers. DMHA has developed partnerships with several entities with juvenile justice responsibilities. DOC has provided fiscal support for the state match for the Home and Community-based Services Medicaid 1915(c) waiver. They are active participants with the Policy Academy. A member of the Juvenile Judges Quality Improvement Committee serves as a Policy Academy delegate, and is involved in facilitating the child welfare screening in her county. The Indiana Criminal Justice Institute (ICJI) has provided funding for the Screening Coordinator position, as well as funding for evaluation and data collection.

#### Strengths

Indiana has been very successful in forging productive partnerships with several child serving agencies. We have been able to "get people to the table" through common values and visions. This did not happen overnight. The significant initiatives are the result of several years' work. Our goal is to bring all child serving entities together in a consolidated "forum" that frames a comprehensive plan for our children.

#### Challenges

Our collaborators and partners are limited in the financial resources they can bring to the table. There is a need for Federal leadership to endorse and support serious cross-systems endeavors. Implementation of the Home and Community-based Services Medicaid 1915(c) waiver requires considerable effort and focus. We have started enrolling children, but are in need of providers for the specialized services.

# Gap

We do not accurately report on the number of children/youth served with substance abuse issues. The Children's subcommittee of the Planning Council and DMHA Bureau of Addiction will explore this issue during the next year.

# **Criterion 4**

# **Services to Rural and Homeless Populations**

Description of Homeless Population and Available Services

The definition of homelessness is persons who have no fixed address. They may live on the street, in a car or an abandoned structure. They may also be living in a shelter, living with family or friends under crowded or stressful conditions, living in deteriorated and unsafe housing often without utilities, or involved in support programs without which there would be a high risk of homelessness.

Local mental health providers offer outreach services to children and families who are homeless. Services include crisis intervention, involvement with the homeless shelters in the community and supervised group living residential arrangements.

# Definition of Rural and Description of Service Barriers

The Indiana definition of rural is "any county with a population of 100 persons per square mile or less." Sixty-six (66) of Indiana's 92 counties meet the definition of rural. The estimated 2005 census shows a total state population of 6,273,130 persons. There are 2,128,463 persons (34%) who live in rural counties.

The Division contracts with 25 providers for services to children with SED. One of these providers serves only rural counties. Nineteen providers serve a mix of rural/urban, and four serve only urban counties. Thirty-four (34) percent of all children and adolescents reported served by providers reside in the 66 rural counties of Indiana.

# Strengths

We are serving an appropriate number of rural youth. We have increased the number of homeless youth served from previous years.

# **Criterion 5**

# **Management Systems**

#### Financial Resources

The Division employs blended funding as it administers both state and federal funds to pay for services for individuals eligible for the Hoosier Assurance Plan. The state's provider contract

for both child and adult populations contains state general revenue funds and federal mental health block grant dollars. Even though these dollars are "blended", there remains a detailed accounting of the various sources for auditing purposes.

#### Role of the Mental Health Block Grant Program in Indiana

The mental health block grant plays an important role in funding services for children and youth with SED. The Division of Mental Health has for many years chosen to pass through ninety-five (95) percent the federal award to providers as a portion of their "state contract". It uses approximately five percent of the award for administrative costs.

# Allocation of Block Grant Funds

The Indiana DMHA does not allocate Block Grant funds at the beginning of a fiscal year to any one provider or to any group of providers. The Block Grant funds are used as the last dollar expended. This ensures that all state funds are expended and not placed at risk of reversion to the general fund. The amount any provider receives in Block Grant funds is dependent on the rate at which a provider uses funds allocated for that provider. All provider contracts contain appropriate language that governs the expenditure of Block Grant funds. The Block Grant funds are expended for treatment according to the rules contained in PL 102-321. At the end of a fiscal year we know exactly how much any provider received from any DMHA fund. In each annual Block Grant Implementation Report we include a table showing the expenditures of funds by each provider. This table has had as few as eight providers and as many as thirty. SED providers have used block grant dollars to provide mental health services for indigent youth.

# Staffing and training for mental health providers

The DMHA has funded a System of Care Technical Assistance Center to support and nurture the development of new SOCs, as well as offer ongoing assistance to existing ones. In state fiscal year 2004 the Technical Assistance Center offered 380 hours of training and consultation; conducted 280 site visits; produced four quarterly newsletters; four quarterly regional trainings; produced a SOC manual and held a statewide Building Systems of Care conference. During state fiscal year 2005 the Division may renew contracts of twelve SOCs and establish new pilot projects, depending upon available funding.

Through the Cultural Competency Enhancement Project, DMHA designs and delivers training to providers to improve mental health/addiction treatment outcomes for the various cultural groups within their service regions. The Training project approaches cultural competency from a systems perspective and addresses critical issues such as client retention, treatment approaches, community involvement and staff skill development. Specific activities include regional trainings, collaboration, assessment and planning, organizational coaching, community inclusion training and an annual conference. During state fiscal year 2004, two-hundred and fifty five providers participated in regional trainings, the annual conference and/or focus groups. Fifteen providers undertook a cultural competency assessment and 13 were offered individualized trainings.

Training of providers of emergency health services regarding mental health

The Division received a \$150,000 award from the Indiana State Department of I

The Division received a \$150,000 award from the Indiana State Department of Health, to plan for emergency response to mental health and addiction issues. A strategic plan was adopted, and

a "Preparedness Assessment of Community Mental Health Centers" was conducted as part of the implementation of the plan. The plans were tested during the 2003 summer floods when 41 of 92 Indiana counties were declared as disaster areas. Three crisis response centers were opened, and 800 people served.

DMHA has been awarded an additional contract through the Indiana Department of Health to develop and validate plans for Mental Health Series for those victimized by emergencies and disasters, including weapons of mass destruction. The CDC Public Health Preparedness and Response to Bio-terrorism Program encompasses comprehensive planning, including responses for children and youth. Children, elderly and previous victims are mandated service populations.

# Strengths

The process of distributing money to providers assures that those dollars are protected from reversions, and motivate providers to serve children.

#### Weaknesses

The funding amount provided for child enrollment is insufficient for even moderate courses of treatment. The lump sum distribution may discourage treatment beyond the intake stages.

# **Summary of Recent, Significant Achievements**

- Awarded 1915 (c) waiver to serve 50 children and participate as presenters in the Rutgers University Audio Conferences for Community-based Treatment alternative for Children (CTAC) grantees.
- Have launched a child welfare screening, as part of a larger initiative to screen in several child-serving systems
- 50% of state( geographically) is covered by Systems of Care, and 75% of the state's child population resides in those areas
- Have submitted a State Incentive Grant proposal to support implementation of an evidence-based practice, and build upon work of the Policy Academy
- Development of statewide family support/organization
- Statewide survey of perceptions of Systems of Care indicate access and quality of care better in systems served by the Technical Assistance Center than in other parts of the state
- Technical Assistance Center recognized as resource throughout the state

#### **DMHA Vision**:

The Indiana Family and Social Services Administration/Division of Mental Health and Addiction has adopted the President's New Freedom Commission's vision:

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and support-essentials for living, working, learning and participating fully in the community.

# Section III. Performance Goals and Action Plans to Improve the Service System

# Section III – Adult Plan Performance Goals and Action Plans to Improve the Service System

The four new Core Performance Indicators are contained in this section under the criteria identified below.

- Increased access to services: Criterion II.
- Reduced utilization of inpatient beds: see note below.
- Evidence based practices: Criterion I, goal F.
- Consumer perception of care: Criterion I, goal A.

*Note*: This office has been reducing reliance on state hospital beds for many years by moving both people and resources from the state operated hospitals to the community. However, this new requirement asks for measures, readmission to inpatient treatment within 30 and 180 days, we do not presently track. We are not able at this time to provide an accurate report on the numbers of people that are returning to inpatient treatment. This will be developed in the coming year. Our state operated facilities data system is not programmed to track readmissions to the hospitals but the data is present. Our CSDS (the community data system) has the data on inpatient use in the community for most providers and can be programmed to track admissions. That will require some changes in the reporting of some providers. It is our intention to have this reporting capability for the implementation report for the 2004 block grant or by next year's plan at the latest.

For several years the Block Grant plan has been tracking consumer satisfaction through the Indiana Consumer Survey. That survey has been replaced by the MHSIP Consumer Survey format. Because of that the goals for consumer satisfaction are being changed to match the new format.

# Criterion 1

# **Comprehensive Community Based Mental Health System**

#### Goals:

- A. To track statewide scores for all five areas (general satisfaction, good service access, quality and appropriateness, participation in treatment, and positive service outcomes) from the consumer satisfaction survey (Brief name: Satisfaction)
- B. To increase by two percent the percent of individuals with a serious mental illness who receive case management. (Brief name: Case Management)
- C. To compare the levels of employment between mental health centers with supported employment programs and mental health centers without supported employment programs. (Brief name: Employment)
- D. To increase the numbers of persons employed. (Brief name: Employed)
- E. To track the independent living arrangement for older adults. (Brief name: Elderly)

F. Increase the number of ACT teams by five. (Brief name: ACT)

#### **Indicators:**

- A. The consumer satisfaction scores for the five areas will be within three percentage points of the prior year.
- B. The percent of individuals with a serious mental illness who are receiving case management services.
- C. Percent of individuals with a serious mental illness who are employed in mental health centers without a supported employment program will be compared to those employed in mental health centers with a supported employment program.
- D. Track over time the numbers of persons reported as employed on the state's data system (CSDS).
- E. Track living arrangement for the older populations.
- F. Track the number of new ACT teams.

#### **Measures:**

- A. Report on the consumer satisfaction scores in all five areas provided by persons with a serious mental illness. This information will be derived from the MHSIP Consumer survey.
- B. Calculate the percent of person receiving case management services and compare that to the percent from FY04. Numerator: persons with SMI receiving case management.
   Denominator: Number of persons with SMI served.
- C. Calculate the percent of individuals with a serious mental illness who are enrolled and who are employed in mental health centers with and without supported employment programs and subtract to show the difference. **Numerator**: individuals with SMI who are employed. **Denominator**: number of SMI enrolled. Subtract to show the difference.
- D. Calculate the percent increase from year to year of the persons employed. Numerator: number employed state fiscal year 2004. Denominator: Number employed state fiscal year 2003.
- E. Using the CSDS system the number of SMI over the age of 65 that are living in a home or apartment will be tracked.
- F. Count the number of new ACT teams.

#### C. PLAN DATA AND IMPLEMENTATION REPORT

Performance Measures A. Satisfaction	FY 03	FY 04 (estimate)	FY 05 (projected) state fiscal	% Attained
B. Case management	58%	58%	58%	
C. Employment	2%	2%	2%	
D. Employed	10,230	10,230	10,230	
E. Elderly	1,425	1,450	1,450	
F. ACT	N/A	N/A	5	

# **Criterion 2**

# **Estimations of Prevalence and Mental Health Systems Data**

This criterion contains a count of the number of persons served compared to the estimate of the number in need of treatment. This goal is indicative of access to treatment and has been tracked for several years. The continual growth in the number served indicates access to services.

#### Goal:

To maintain the percentage of individuals with a serious mental illness receiving publicly funded care. (Brief name: persons served)

#### **Indicator:**

Percentage of individuals with a serious mental illness who receive publicly funded services.

#### **Measure:**

Calculate the percent of individuals with a serious mental illness who received services through the mental health centers and compare that to the percent of individuals with a serious mental illness estimated who were served the previous year. **Numerator**: the number of persons with SMI who receive publicly funded services under the HAP. **Denominator**: The number of persons with incomes at or below 200% of the federal poverty level who are estimated to be in need of services.

# C. PLAN DATA AND IMPLEMENTATION REPORT

Performance	FY 03	FY 04	FY 05	% Attained
Measures		(estimate)	(projected)	
A. Persons served	70%	70%	70%	
	48,000	48,000	48,000	

# **Criterion 4**

**Targeted Services to Homeless Populations Targeted Services to Rural Populations** 

#### Goals:

- A. To maintain the number of homeless served by the publicly funded mental health system at the state fiscal year 04 levels. (Brief name: homeless)
- B. Maintain the state fiscal year 04 levels of persons served in rural areas of the state. (Brief name: rural)

#### **Indicators:**

- A. The number of homeless individuals with a serious mental illness who receive mental health service.
- B. The number of rural individuals with a serious mental illness who receive mental health services.

#### **Measures:**

- A. Count the number of individuals with a serious mental illness who are reported as homeless and who receive services.
- B. Count the number of individuals with a SMI served in rural areas of the state.

#### C. PLAN DATA AND IMPLEMENTATION REPORT

Performance	FY 03	FY 04	FY 05	% Attained
Measures		(estimate)	(projected)	
A. Homeless	2,500	2,500	2,500	
B. Rural	13,500	13,500	13,500	

# **Criterion 5**

**Management Systems** 

#### Goal:

A. To stay within 10% of the FY 04 expenditure of DMHA funds for the purchase of services for individuals with a serious mental illness. (Brief name: DMHA funds)

# **Indicator:**

A. Amounts of DMHA funds expended.

# Measure:

A. Count the amount of funds allocated for services for individuals with a SMI.

# C. PLAN DATA AND IMPLEMENTATION REPORT

Performance	FY 03	FY 04	FY 05	% Attained
Measures		(estimate)	(projected)	
A. DMHA funds	\$ 82,500,000	\$ 82,500,000	\$ 82,500,000	

# SECTION III: Children's Plan Performance Goals and Action Plans to Improve the Service System

The four core performance indicators to be addressed are contained in this section under the criteria below. They will also be noted with \*.

- Increased access to services: Criteria I, II
- Reduced utilization of inpatient beds: see note below
- Evidence-based practices: see note below
- Consumer perception of care: Criterion I, goals; Criterion III, goals

<u>Note 1</u>: This office has been reducing reliance on state hospital beds for many years by moving both people and resources from the state operated hospitals to the community. However, this new requirement asks for measures, readmission to inpatient treatment within 30 and 180 days, which we do not presently track. We are presently unable to provide an accurate report on the numbers of people that are returning to inpatient treatment. This will be developed in the coming year. Our state operated facilities data system is not programmed to track readmissions to the hospitals but the data is present. Our CSDS (the community data system) contains the data on inpatient use in the community for most providers and can be programmed to track admissions. It is our intention to have this reporting capability for the implementation report for the 2004 block grant or by next year's plan at the latest.

<u>Note 2:</u> We are working to support evidence-based practices and practice-based evidence through educating providers about emerging children's EBPs. We hope to convene a statewide conference addressing integrated treatment for mental health and substance abuse in 2005. Systems of Care are considered a promising practice.

# Criterion 1

# **Comprehensive Community -based Mental Health Service Systems**

Indiana continues to serve an increasing number of children with serious emotional disturbances (SED). In the past two years the numbers have increased by 9% and 14% respectively.

The delivery of case management services indicates that the child/family is accessing important community and support services.

Family/caregiver satisfaction with services is a critical indicator that services are accessible, appropriate and family-friendly.

Enrollment in Systems of Care (SOC) was tracked for the first time in 2004. With the growth of SOCs we anticipate increased enrollments.

The Office of Consumer and Family Affairs (OCFA) partners with the Indiana Federation of Families for Children's Mental Health (IFFCMH) to develop and deliver trainings, consultation, support and a conference to further the development of family voice within Systems of Care.

# **Performance Indicator Description**

#### Goals:

- A. Maintain the number of enrolled children who receive mental health case management\* (access)
- B. Obtain overall services satisfaction data from parents/caregivers\* (perception)
- C. Obtain overall services access data from parents/caregiver \* (perception)
- D. Continue training and outreach services of Office of Consumer Affairs
- E. Increase the number of children enrolled in Systems of Care by 10%\* (access)
- F. Initiate training, consultation for youth/family groups by Indiana Federation of Families

**Population:** Children diagnosed as seriously emotionally disturbed

**Criterion:** Comprehensive community-based mental health service systems Brief name: case management, family satisfaction, consumer services, systems of care and family voice.

#### **Indicators:**

- A. Children/youth enrolled in provider programs that receive case management services
- B. Parents/caregivers who indicate they are overall satisfied with services
- C. Parents/caregivers who indicate they are satisfied with access to services
- D. Report training and outreach schedule of Office of Consumer and Family Affairs
- E. Track number of youth enrolled in provider programs that indicate they are being served in a SOC
- F. Track numbers of training, consultations, presentations by IFFCMH

#### **Measures:**

- A. Percentage of children with SED receiving case management services compared to the total number of children served
- B. Percent of families/caregivers who say they are satisfied with services
- C. Percent of families/caregivers who say that service access was good
- D. Percent increase in training hours from previous year
- E. Percent increase in number of children with SED enrolled in SOC compared to the total number of children served
- F. Report numbers of training, consultation, presentations

# C. PLAN DATA AND IMPLEMENTATION REPORT

Performance	FY 03	FY 04	FY 05	% Attained
Measures		(estimate)	(projected)	
A. Case	69%	70%	70%	
Management				
B. Family	70.1%	70%	70%	
Satisfaction				
C. Access to	80.6%	80%	80%	
Services				
D. Consumer	N/A	N/A	N/A	
Services				
E. Systems of Care	N/A*	2.6%	3%	
F. Family Voice	N/A**	N/A**	N/A**	

<sup>\*</sup>Note: Data not collected in FY 2003

# Sources of information:

A, D and E; Community Services Data System (CSDS): the DMHA data collection and management system.

B and C: Provider Report Card- Consumer Satisfaction Survey

F: Provider quarterly reports

# **CRITERION 2**

# Mental Health Systems Data Epidemiology

During state fiscal year 2004 mental health providers contracting with the Division reported serving a total of 24,411 children and youth that are SED enrolled under the Division's Hoosier Assurance Plan (HAP). This total number of children served will be revised in the Implementation report once final end of year data has been collected.

#### PERFORMANCE INDICATOR DESCRIPTION

#### Goal:

A. Maintain the number of children and youth with SED served by DMHA supported mental health providers.\* (access)

Population: Children diagnosed as seriously emotionally disturbed

Brief Name: Children and Youth Served

#### **Indicator:**

Children and youth (0-17) with SED enrolled in DMHA funded mental health programs.

<sup>\*\*</sup>Note: Data not available at this time but will be provided during federal review process.

#### Measure:

Number and percent of enrolled and served children/youth compared with the prevalence rate for SED.

#### C. PLAN DATA AND IMPLEMENTATION REPORT

Performance	FY 03	FY 04	FY 05	% Attained
Measures		(estimate)	(projected)	
Children & Youth	23,013	24,411	24,500	
Served				
Children & Youth	49%	49%	49%	
Penetration Rate				

#### Source of Information:

Community Services Data System (CSDS); a DMHA data management system.

# **CRITERION 3**

#### **Children's Services**

The Division of Mental Health and Addiction's 2005 priorities are:

- Children
- Employment
- Recovery outcome results

The children's priority encompasses Systems of Care development, implementation of the 1915 (c) Medicaid Home and Community-based waiver and the early identification and intervention initiative. Services from the Technical Assistance Center for Systems of Care and Evidence-based practices for children and their families support these priorities.

The Division is working to educate providers about evidence-based practices for children with co-occurring mental health and substance abuse issues.

#### **Performance Indicator Description**

#### Goals:

- A. Increase number of children/youth receiving treatment for both substance abuse and SED.\* (access)
- B. Increase community-based mental health services for children/youth with SED through expanded collaboration with youth serving entities.\* (access)

Brief Name: Children/youth with dual diagnoses; children with SED who are referred from other service entities.

#### **Indicators:**

- A. Dually diagnosed children with SED who also receive services for substance abuse
- B. Children with SED referred from local Offices Family Resources
- C. Children with SED referred from local schools
- D. Children with SED referred from local juvenile courts

# **Measures:**

- A. Number of children with SED and substance abuse problems who receive treatment for both conditions.
- B. Number of enrolled children with SED who are referred by county Offices of Families and Children (OFC).
- C. Number of enrolled children with SED who are referred by local school systems.
- D. Number of enrolled children with SED who are referred by county juvenile justice system

#### C. PLAN DATA AND IMPLEMENTATION REPORT

Performance	FY 03	FY 04	FY 05	% Attained
Measures		(estimate)	(projected)	
Children & Youth	6%	6%	6%	
with Co-Occurring				
Disorders				
Referred by OFC	15%	15%	15%	
Referred by school	18%	18%	18%	
systems				
Referred by Juvenile	6%	6%	6%	
Justice				

#### Source(s) of Information:

A, B, C, D- Community Services Data System (CSDS); a DMHA data management tool.

# **CRITERION 4**

# **Targeted Services to Rural and Homeless Populations**

Sixty of Indiana's 92 counties are designated as rural according to the state definition. The state's 2000 estimated census population is 6,080,000 persons of which 1,555,000 (25.6%) live in rural areas. The Division's managed care mental health providers appear to be serving an appropriate percentage of rural children and youth.

#### Goals:

- A. Maintain services to eligible children and families who are homeless. \* (access)
- B. Maintain the level of services to children living in rural areas of the state\*(access)

Population: Children diagnosed as seriously emotionally disturbed

Brief Name: Services to homeless and rural populations.

# **Indicators:**

A. Children and their families who are homeless and who receive needed mental health services.

B. Rural children/youth who receive the appropriate levels of mental health services

#### **Measures:**

- A. Total number of homeless SED children and families who are served during the year
- B. Percent of rural SED children/youth receiving services compared to total SED served during the year.

#### C. PLAN DATA AND IMPLEMENTATION REPORT

Performance	FY 03	FY 04	FY 05	% Attained
Measures		(estimate)	(projected)	
Homeless Services	77*	85	85	
Children & Youth				
Rural Services –	32%	32%	32%	
Children & Youth				

<sup>\*</sup>Note: It is difficult to accurately report number of homeless youth served. Often there is reluctance to report homelessness due to factor such as serial living arrangements, domestic violence protective factors, and custody issues.

#### Source(s) of Information:

A. and B. Community Services Data System (CSDS); a DMH data management tool.

# **CRITERION 5**

# **Management Systems**

All Federal block grant dollars are spent directly on services. The greatest percentage goes to services for SED children, through providers. A small contract for Family Voice is supported by the Block Grant.

#### Goal:

A. Maintain funding from state and federal sources for mental health services for children.

Brief Name: State mental health and Medicaid funding sources for children and Family Voice.

#### **Indicators:**

- A. Maintain level of state contract dollars (general funds) for services for children
- B. Increased billing of Medicaid Rehabilitation Option dollars for children
- C. Renew contracts for pilot systems of care development
- D. Provision of block grant funding for development of parent/youth support network

E. Present statewide conference for Family Voice

#### **Measures:**

- A. The amount of state contract dollars allocated for children as a portion of the total DMHA community based service dollars.
- B. The amount of Medicaid Rehabilitation Option dollars billed for children's services as a portion of total MRO dollars billed by DMHA.
- C. Development of system of care projects by end of state fiscal year 2005
- D. Number of hours for consultation, presentations, mentoring
- E. Completion of state conference for Family Voice

# C. PLAN DATA AND IMPLEMENTATION REPORT

Performance	FY 03	FY 04	FY 05	% Attained
Measures		(estimate)	(projected)	
Percent allocated for	8.4%	14%	14%	
Children & Youth				
Percent MRO	37.4%	39%	39%	
participation				
Number SOC sites	20	27	27	
Consumer Services	N/A*	N/A*	N/A*	
Family Voice	N/A*	N/A*	N/A*	

<sup>\*</sup>Note: Date not available at this time but will be provided during federal review process.

# Source(s) of Information:

A. and B. Community Services Data System (CSDS); a DMH data management system.

C. D. and E. Written documents from the pilot projects, from the state IFFCMH Office and conference evaluations.